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C321-92-2160
May 20, 1992

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report

This letter forwards one (1) copy of Licensee Evert Report 92-003.

Sincerely,

John J. Barton
Vice President and Director
Oyster Creek

JJB\JJR
Enclosure

cc: Administrator, Region 1
Senior NRC Resident Inspector
Oyster Creek NRC Project Manager

(LER-COVLTRS)

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1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Oyster Creek	0 5 0 0 0 2 1 9	1 OF 0 1 3

TITLE (4)

Inadvertent Manual Activation of an Engineered Safety Feature Due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 4	2 0	9 2	9 2	- 0 0 3	- 0 0	0 5	2 0	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10) 1 0 0	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Paul Cervenka	AREA CODE 6 0 9 9 7 1 - 4 8 9 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO			

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On April 20, 1992 at approximately 1255 hours, the reactor was operating at approximately 100% power and Procedure 607.4.004, Containment Spray and Emergency Service Water System 1 Pump Operability and In-service Test was in progress. The operator performing the surveillance overlooked a portion of a step in the procedure to stop the Containment Spray pump and proceeded to next step which positioned the system mode switch to the AUTO position. This lines up the system valves for the Drywell Spray mode. The operator recognized the error and secured the Containment Spray Pump within 29 seconds. During this period approximately 825 gallons of Torus water entered the Drywell. The cause of this occurrence is attributed to operator error. A contributing cause to this event was the involved procedure step which contained several action statements.

The Plant Transient Review Group (PTRG) was convened to determine the significance. The results of the review determined that all safety related functions would be unaffected by the event with the possible exception of the acoustic and thermocouple monitors associated with the main steam safety and electromatic relief valves. The PTRG recommended testing of these systems, which was started at 1730 hours and successfully completed at 2320 hours. A critique was held, and appropriate personnel actions were taken with respect to the individual involved. Procedural changes have also been made to separate the multiple action statements contained in the involved procedure step. An ongoing procedure upgrade program includes a review of procedures for multiple action statements.

DATE OF OCCURRENCE

The event occurred on April 20, 1992 at approximately 1255 hours.

IDENTIFICATION OF OCCURRENCE

While performing a surveillance test on the Containment Spray System, a portion of a step was overlooked which resulted in an inadvertent manual actuation of an engineered safety feature. This event is considered reportable in accordance with 10CFR 50.73.(a).(2).(iv)

CONDITIONS PRIOR TO OCCURRENCE

The Containment Spray (EIIS-BP) and Emergency Service Water (EIIS-BS) System 1 Pump Operability and Inservice Test procedure was in progress. The reactor was operating at approximately 100% power.

DESCRIPTION OF OCCURRENCE

On April 20, 1992 at approximately 1255 hours, Procedure 607.4.004, Containment Spray and Emergency Service Water System 1 Pump Operability and In-service Test was in progress. The Containment Spray System valves were lined up in the test mode with Containment Spray pump 51B operating. In this mode water from the Torus is pumped through the Containment Spray heat exchangers and then returned to the Torus via a test loop. The operator performing the surveillance overlooked a portion of a step in the procedure to stop the Containment Spray pump and proceeded to the next step which positioned the system mode switch to the AUTO position. The AUTO position lines up the system valves (CFI-ISV) for the Drywell Spray mode. The operator recognized the error and secured the Containment Spray Pump within 29 seconds. During this period approximately 825 gallons of Torus water entered the Drywell. Drywell pressure prior to the event was 1.19 psi. Drywell pressure initially decreased by .15 psi due to the cooling effects of the spray and then increased to a peak of 1.4 psi which was only .2 psi above the initial drywell pressure. Drywell bulk temperature decreased by approximately six degrees. The Drywell Sump High Leakrate Alarm (EIIS-IJ) was received and cleared approximately five times during the next 40 minutes due to the event. The plant continued to operate at approximately 100% power during and after the event.

APPARENT CAUSE OF OCCURRENCE

The cause of this occurrence is attributed to operator error. The operator overlooked an action statement to stop the Containment Spray Pump contained within a step in the procedure and also failed to utilize self checking methods before performing the next critical step. A contributing cause to this event was the involved procedure step which contained several action statements.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The Plant Transient Review Group (PTRG) was convened to determine the significance of this event. A review of plant data indicated there were no immediate or obvious adverse effects on any equipment contained in the drywell. A listing of safety related equipment contained in the Drywell was reviewed with respect to the Environmental Qualification and failure mode of the equipment to determine if any safety related function was in question.

The results of the review determined that all safety related functions would be unaffected by the event with the possible exception of the acoustic and thermocouple monitors associated with the main steam safety and electromatic relief valves. The PTRG recommended testing of these systems, which was started at 1730 hours and successfully completed at 2320 hours.

Based upon the above safety significance of this event is considered minimal.

CORRECTIVE ACTION

A critique was held and appropriate personnel action was taken with respect to the individual involved in this event.

Procedural changes were made in the referenced procedure to separate the multiple action statements contained in the involved procedure step. An ongoing procedure upgrade program includes a review of procedures for multiple action statements.

Management discussions with the operators involved concerning the need to perform Self-Checking, and the Work Performance Standard on Procedure Compliance were held. Management determined the appropriate training/requalification of the operator performing the surveillance, prior to resuming licensed duties.

The expectations of Operations Management regarding compliance with the Operations Department Standard on Procedure Compliance have been communicated to all Operations Department Personnel.

A critique of this event was issued as required reading for all Licensed/Non-Licensed Operations personnel and all staff License or Certification holders.

Development of the concept of Crew Self-Checking, including a training module for presentation to each of the operating crews will be considered for implementation.

Evaluation of the need for and, where necessary, refresher self-checking training will be provided for all Licensed/Non-Licensed Operations Department personnel.

SIMILAR EVENTS

None.